Kansas
Department of Health and Environment

OFFICE OF THE INSPECTOR GENERAL
2013 ANNUAL REPORT

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Dear Reader:

It is our pleasure to submit the annual report of the Kansas Department of Health and Environment (KDHE) Office of Inspector General (OIG) for Calendar Year 2013. This report is issued pursuant to the requirements of K.S.A. 75-7427 and is respectfully submitted to:

- The people of the State of Kansas
- The Governor of the State of Kansas, the Honorable Sam Brownback
- Honorable members of the Kansas Senate's Committee on Ways and Means
- Honorable members of the Kansas House of Representatives' Committee on Appropriations
- The Secretary of the Kansas Department of Health and Environment, Dr. Robert Moser, M.D.
- Director of the Division of Health Care Finance, Ms. Kari Bruffett
- The Legislative Post Auditor, Mr. Scott Frank
- The Audit Committee for the KDHE Office of Inspector General

This report provides an overview of the KDHE OIG and describes the OIG's activities and accomplishments in calendar year 2013. It also provides general statistics on provider billing, payments and sanctions submitted to the OIG by the Kansas Department for Aging and Disability Services and the KDHE Division of Health Care Finance.

We hope this report provides you with valuable information and we welcome any questions or comments you may have regarding the report contents or our operations. Please feel free to contact us at OIG@kdheks.gov or (785) 296-1076.

Introduction to the Office of Inspector General

During the 2007 Legislative Session, the Kansas Legislature created an Office of Inspector General (OIG) within the Kansas Health Policy Authority (KHPA). The Inspector General duties include carrying out the responsibilities of the Office of Inspector General in accordance with KSA 75-7427. Executive Reorganization Order 38, dated February 4, 2011, abolished KHPA and transferred all statutory obligations of KHPA to the newly formed Division of Health Care Finance (DHCF) within the Kansas Department of Health and Environment (KDHE). The OIG reports directly to the Secretary of Health and Environment, a structure that complies with standards of the Association of Inspectors General. The Secretary has the authority to ensure that audit reports receive due attention, to require DHCF management responses to IG recommendations, to ensure that corrective actions are accomplished, and to ensure that the OIG receives an appropriate budget authorization to carry out its statutorily defined mission.

The KDHE OIG's enabling statute is K.S.A. 75-7427. The OIG's mission is to:

- Provide increased accountability and integrity in DHCF programs and operations.
- Help improve DHCF programs and operations.
- Identify and deter fraud, waste, abuse and illegal acts in the State Medicaid Program, the MediKan Program and the State Children's Health Insurance Program.

To fulfill its mission, the KDHE OIG conducts:

- Audits of DHCF programs, contractors, vendors or health care providers.
- Investigations of fraud, waste, abuse, and illegal acts by DHCF or its agents, employees, vendors, contractors, consumers, clients, health care providers or other providers.
- Reviews, inspections, or evaluations.

Audits are formal evaluations of an organization, its systems, processes, projects or products. Performance audits examine the effectiveness or efficiency of a program or operation. The overarching goal of all OIG audits is to review the quality of DHCF programs and processes and recommend policies which enhance the prevention and detection of fraud, waste and abuse. The OIG conducts its audits in a manner consistent with generally accepted government auditing standards developed by the U.S. Government Accountability Office (GAO). OIG audit topics are identified through periodic risk assessments, suggestions by DHCF and KDHE management, suggestions from members of the Legislature, or from OIG audit staff.

Investigations attempt to determine the validity or extent of reported allegations/incidents, the amount of loss, and what weaknesses may have existed that led to the allegations/incidents. Investigative reports may make corrective action recommendations intended to avoid similar problems in the future. The OIG conducts investigations that are consistent with the principles

and quality standards set out for investigations by the Association of Inspectors General. Topics for OIG investigations are identified by audit work performed by OIG staff as well as referrals from DHCF staff, legislators and the general public. The results of investigations are reported to DHCF and KDHE management and are referred, if necessary, to the Medicaid Fraud Control Unit (MFCU), a division of the Kansas Attorney General's Office, for further investigation or prosecution.

Reviews are inquiries into a specific programmatic aspect of DHCF's operations. Reviews may attempt to determine many issues, such as whether a component of the program is effective and efficient or whether the program component has good strategies to safeguard the appropriate use of state funds. Like investigations, the OIG will conduct reviews which are consistent with the principles and quality standards set out for inspections, evaluations and reviews by the Association of Inspectors General.

The results of all audits are presented in formal, written audit reports. Members of the Kansas Legislature, the public and other interested parties may access audit reports, annual reports and other information on our website at http://www.kdheks.gov/hcf/oig/.

Members of the public who suspect fraud, waste or abuse in the State Medicaid Program, MediKan or the State Children's Health Insurance Program are encouraged to email their concerns to the OIG at OIG@kdheks.gov or call 785-296-1076.

As required by K.S.A. 75-7427, the KDHE OIG will report findings of fraud, waste, abuse or illegal acts to KDHE and also refer those findings to the Attorney General via the Medicaid Fraud Control Unit (MFCU).

Office of Inspector General Staff

The OIG is comprised of the Inspector General and two staff members who are authorized to conduct independent and ongoing evaluations of DHCF and its programs and operations, including audits, investigations and program reviews. At the present time, the position of Inspector General has been vacant since January 3, 2014 and recruitment to fill this position is underway. The position of data auditor under the IG has also been vacated recently and the position is being advertised with expectation to have all positions filled by April 2014. The Inspector General is appointed by the Secretary of KDHE and confirmed by the Senate.

Calendar Year 2013 Activities and Accomplishments

The OIG looks forward to continuing its service to the citizens of the State of Kansas and fulfilling the mission of providing increased accountability and integrity in KanCare and other DHCF programs and operations. The goal continues to be helping to improve DHCF programs and operations, and identifying and deterring fraud, waste and abuse in KanCare, MediKan, the State Employees Health Plan, and the State Self Insurance Fund.

Special Reports

I. KMAP Payments for Concurrent Inpatient and Personal Care Services

This special report had two objectives. The first was to evaluate the Medicaid program's compliance with the laws, regulations, and policies restricting the provision of personal care services to recipients during their inpatient stay. The second was to identify any noncompliant, paid PCS claims and refer the billing providers to the Medicaid Fraud Control Unit and to the Medicaid Program Integrity unit for appropriate action.

The report is based on an analysis of claims for personal care services as well as inpatient services. Only claims submitted for services rendered between January 2012 and December 2012 were considered.

Our tests for overlapping services showed that some beneficiaries were provided with paid PCS services during their inpatient stay, contrary to federal statute, code of federal regulations, and Medicaid program policy.

PCS amounts of overlap per beneficiary ranged from $30.60 to $5,246.74. The approximate total of overpayments was $34,856.

In our analysis of overlapping claims, the OIG found thirteen beneficiary cases (one case involved two agencies) that had possible overpayments over $1000. We looked into these cases further and referred them to the Medicaid Fraud Control Unit (MFCU) at the Kansas Office of the Attorney General. The total of these cases is $27,598.72.

The OIG also recommended that DHCF consider investigating suspected overpayments where personal care services overlap with inpatient claims and recoup funds where needed.

During the review, the OIG requested admission and discharge records from inpatient providers to verify the services rendered to specific beneficiaries. One hospital was unable to furnish the documentation for some of the Medicaid patients for whom they were paid. This is against the statutory requirements as provided in K.S.A. 21-3848 (failure to maintain adequate records) and

the terms of the provider contract. Therefore, that hospital was referred to MFCU for further investigation.

II. A Review of PCAs with Multiple Beneficiaries and Agencies

Medicaid provides services through many different programs. Some services, such as personal care services (PCS) provided through the home and community based services (HCBS) waiver, are provided while the recipient is in their own home. Personal care services are nonmedical services provided to assist with activities of daily living, such as bathing, dressing, light housework, medication management, meal preparation, and transportation. Under Federal law, PCS must be provided in a home or location specified by the State and must follow a plan of care (POC) subject to approval or authorized by the State Medicaid agency.

The objective of this desk review was to identify any paid PCS claims showing overlaps where the PCS worker billed for providing services to more than one beneficiary at a time. The workers were employed by more than one agency under different worker identification numbers. Where necessitated, the providers were referred to the MFCU and to the Medicaid Program Integrity unit for appropriate action. Policy requirements for PCS eligibility are as follows:

Policy Requirement (Kansas Medicaid Program Policy)
The State of Kansas' policy on HCBS services, as stated in HCBS provider manuals, prohibits personal services workers from working and being paid for multiple HCBS beneficiaries at the same date and time.[1]

Our analyses showed that the worker submitted and received payment for hours of overlapping services in 49 of the 50 cases originally investigated, violating Medicaid program policy.

PCS amounts of overlap per worker ranged from $67.92 to $18,279.00. Workers were employed by two to five agencies during the time periods reviewed. The approximate total of overlapping payments was $142,648.78.

In our analysis of overlapping claims, the OIG found 38 workers whose cases necessitated referrals to MFCU. The OIG completed and sent these referrals to MFCU and also sent copies to the State's Medicaid Program Integrity unit for notification and referral as well. The amount of overlapping payments for these 38 workers totaled $139,894.19.

The Office of Inspector General made the following recommendations:

[1] KMAP HCBS PD Provider Manual Personal Services, p. 8-10 and KMAP HCBS FE Provider Manual Attendant Care Services, p. 8-10

1. MFCU should consider investigating the 38 referred cases of overlap where the worker provided services to more than one beneficiary concurrently in violation of State Medicaid program policy.

2. DHCF should consider investigating the 38 referred cases of overlap where the worker provided services to more than one beneficiary concurrently in violation of State Medicaid program policy and take the appropriate administrative action.

3. DHCF should implement measures to prevent duplicate Medicaid payments for services rendered by the same worker to different beneficiaries at the same time, or at least to improve its ability to monitor and detect them. One suggestion would be to follow HHS OIG's recommendation to either enroll all PCS attendants as providers or require all PCS attendants to register with the State Medicaid agency and assign each attendant a unique identifier.

Audit

III. A Follow-Up Audit of Kansas' Medicaid Claims Processing

In January 2010, the KDHE Office of Inspector General (OIG) released an audit report entitled "*A Performance Audit of Kansas' Medicaid Claims Processing: Does KHPA Have Effective Oversight of its Fiscal Agent's Medicaid Claims Processing to Ensure Timeliness and Accuracy of Payments?"* The audit found a number of deficiencies in the processing of claims or management oversight of the fiscal agent, resulting in the issuance of a total of eight recommendations.

The Medicaid agency agreed with six of the eight recommendations and responded that they would be implementing corrective action to mitigate identified risks. Management agreed in principle with one recommendation but responded that the action already being taken was adequate to address the perceived risk. They did not agree with the auditors on one recommendation.

The objectives of the follow-up audit were to determine if the agency implemented corrective action on the six recommendations it agreed to and whether the actions taken were adequate to address the findings cited in the original claims management audit report.

The OIG found that for all recommendations where the Medicaid agency had planned corrective action the action taken was sufficient to mitigate the identified risks and therefore all the recommendations are now closed.

2013 Accomplishments

In addition to completing the special reports and the follow-up audit summarized above, the OIG accomplished the following in CY 2013.

- OIG staff attended three training sessions at the Medicaid Integrity Institute. All training expenses are funded by the U.S. Department of Justice.
- The OIG met regularly with and coordinated its efforts with the Attorney General's Medicaid Fraud Control Unit (MFCU), KanCare MCO representatives, and DHCF's Program Integrity personnel.
- The OIG kept updated on the transition to KanCare and attended KanCare Oversight Committee meetings, Advisory Council meetings, external workgroup meetings, public forums and KanCare public conference calls.
- The OIG researched all incoming calls and concerns and investigated or referred to the appropriate agency, if necessary.
- The OIG began what it intends to be a continuous project of reviewing for instances of fraud in Personal Care Services billed to Medicaid. This project will involve analyzing State Medicaid data as well as data from other agencies such as the Kansas Department of Labor (KDOL).
- The OIG expanded its networking with other state fraud personnel in the Department of Children and Families and the Department of Labor.
- The OIG has significantly increased the number of cases referred to the Attorney General's Medicaid Fraud Control Unit. The number of referrals has gone from averaging two each year to 17 in SFY 2013 and now to 39 in the first six months of SFY 2014.
- The OIG updated its website with an online fraud referral form.

2014 Goals

- Continue working on project of reviewing for instances of fraud in Personal Care Services billed to Medicaid. This project involves analyzing State Medicaid data as well as data from other agencies such as the Kansas Department of Labor (KDOL). The OIG will work closely with the Attorney General's MFCU and federal authorities, as needed, in the process of investigation and prosecution of cases it finds and refers. The OIG will also continue to provide recommendations and suggest solutions that will help prevent such instances of fraud from occurring.
- Continue networking and collaboration with other state fraud personnel. This can help increase the effectiveness of fraud detection and prevention efforts of all departments involved.

- Research allegations and complaints of fraud, waste, abuse and illegal acts and either conduct an investigation or review or complete preliminary research and refer the allegation to the appropriate agency or law enforcement.

- Meet monthly with the Attorney General's Medicaid Fraud Control Unit, Division of Health Care Finance Program Integrity staff, and KanCare Managed Care Organization representatives, helping ensure a coordinated coverage of program integrity efforts.

- Continue to pursue staff training that helps the office in its fraud detection and prevention efforts.

Fiscal Year 2013 Statistics

K.S.A. 75-7427 requires this report to include information from other entities that administer or manage programs under Medicaid. The sources of the information below include the Kansas Department for Aging and Disability Services (KDADS), KDHE Division of Health Care Finance (DHCF) and its fiscal agent, HP Enterprise Services. The Office of Inspector General presents statistical figures from other agencies without auditing or evaluating the information for accuracy.

Provider Sanctions, Billing and Payments

Three broad types of health care providers who provide services to Medicaid may be sanctioned for improper behavior: (1) nursing facilities and long-term care units; (2) providers contracting with managed care organizations (MCOs); and (3) fee-for-service providers. The reported statistics for each type of provider are found below. For purposes of comparison with previous years, some statistics are shown for SFY 2011, SFY 2012 and SFY 2013.

Federal certification enforcement actions of Medicaid-only certified nursing homes are handled by the Kansas Department for Aging and Disability Services (KDADS).

Table 1: Nursing Facility Sanctions

	SFY 2011	SFY 2012	SFY 2013
Total number of Medicaid-only Nursing Facilities	63	59	52
Number of Nursing Facilities which are Long Term Care Units (LTCUs)	43	29	28
Number of Terminations	0	0	1
Number of Civil Monetary Penalties imposed	6	1	5
Number of Surveys where NF was non-compliant	26	14	12

Source: KDADS

Sanctions of *providers credentialed by MCOs* are imposed by the MCOs with whom providers have a direct relationship.

Table 2: Managed Care Organization (MCO) Provider Sanctions

	SFY 2011	SFY 2012	SFY 2013
Number of Providers placed on Corrective Action Plans	60	26	0
Number of Providers Terminated	40	24	15*
Number of Cases forwarded to AG's Medicaid Fraud Control Unit	0	6	1

*Additional information was received from DHCF after the original report was mailed. Therefore, this number has been corrected.
Source: KDHE DHCF

Sanctions of *providers in the fee-for-service and waiver programs* are handled by DHCF staff in conjunction with the state fiscal agent, who reports the following statistics:

Table 3: State and Fiscal Agent Sanctions			
	SFY 2011	**SFY 2012**	**SFY 2013**
Number of Providers on Pre-pay Review Status	0	1	1
Number of Providers Terminated	3	0	8
Number of Providers Placed on Corrective Action Plans	2	5	9
Number of Provider Cases of Suspected Fraud Referred to AG's MFCU	25	75	10
Total Number of Beneficiaries Placed on Lock-In Status	495	136	72
Source: KDHE DHCF			

DHCF Utilization Management reports show the following amounts of costs identified and recovered during State Fiscal Year 2013:

Table 4: Cost Recoveries - SFY 2013		
	Identified	**Recovered**
State Fiscal Agent SURS	$3,019,686	$2,229,871
State External Quality Review Organization (KFMC)	$8,495,961	$8,495,961
MFCU Criminal and Civil Cases	$229,402	$235,321
MFCU Global Settlements	$0	$23,826,924
Medicaid Integrity Contractor	$498,779	$335,587
Recovery Audit Contractor	$1,337,694	$1,298,272
Source: KDHE Division of Health Care Finance		

The OIG researches incoming allegations and complaints of fraud, waste, abuse and illegal acts and either conducts an investigation or review or completes preliminary research and refers the allegation to the appropriate agency or law enforcement.

Table 5: OIG Case Activity			
	SFY 2011	**SFY 2012**	**SFY 2013**
Number of Preliminary Investigations of Provider Fraud or Abuse	4	3	4
Number of Cases Referred to the AG's Medicaid Fraud Control Unit	1	2	17
Number of Cases Referred to Other State Agencies (DHCF, DCF & KDADS)	2	4	20
Source: KDHE OIG			

Aggregate Information on Provider Billing and Payments

The following aggregate provider billing and payment information was supplied by KDADS, DHCF and HP Enterprise Services (DHCF's fiscal agent).

HP Enterprises reported processing approximately 14.8 million claims while the MCOs processed approximately 9.1 million claims. This resulted in payments of almost $2.9 billion. That number includes payments for fee-for-service and capitation payments to pre-KanCare and KanCare MCOs. Of the $2.9 billion, approximately $1.1 billion was for capitation payments made to the MCOs in SFY 2013.